APPLICATION FOR LICENSURE BY EXAMINATION FOR GRADUATES OF U.S. NURSING SCHOOLS

State Form 50024 (R / 7-03)
Approved by State Board of Accounts, 2003

INDIANA STATE BOARD OF NURSING
Health Professions Bureau
402 West Washington Street, Room W066
Indianapolis, Indiana 46204
(317) 234-2043
http://www.state.in.us/hpb/boards/isbn/
email: hpb2@hpb.state.in.us

HEALTH PROFESSIONS BUREAU USE ONLY	
Application fee	Receipt number
Date fee paid (*month, day, year*)	License number
Issuance date (*month, day, year*)	

PLEASE TYPE OR PRINT CLEARLY. ANSWER ALL QUESTIONS.

Are you applying for a license as a:
☐ Registered Nurse ☐ Licensed Practical Nurse

Have you taken the NCLEX examination previously?
☐ Yes ☐ No

If Yes, when and in what state?

Name (*last, first, middle, maiden*)

List other last names you have used

Street address (*number and street or Rural Route*)

City

State

ZIP code

Daytime telephone number (*include area code*)
( )

Date of birth (*month, day, year*)

Place of birth (*city and state*)

Social Security number *

* Your Social Security number is being requested according to IC 4-1-8-1. The request is MANDATORY and this application cannot be processed without it.

E-mail address

NURSING EDUCATION

**** DO NOT USE THIS APPLICATION IF YOU GRADUATED FROM A NURSING PROGRAM OUTSIDE OF THE UNITED STATES. REQUEST A FOREIGN GRADUATE EXAMINATION APPLICATION FROM THE HEALTH PROFESSIONS BUREAU.***

Name of nursing school

Location (*city and state*)

Date of enrollment (*month, day, year*)

Date of graduation (*month, day, year*)

CHECK THE TYPE OF PROGRAM FROM WHICH YOU GRADUATED

RN PROGRAM
☐ Associate Degree (2 year)
☐ Baccalaureate Degree (4 year)
☐ Diploma (3 year)

☐ **PN PROGRAM**

HIGH SCHOOL EDUCATION

Name of school

Location (*city and state*)

Date of graduation (*month, day, year*)

If you are not a high school graduate, have you taken and passed the GED? (*If yes, submit an official copy of your GED scores*)
☐ Yes ☐ No

Do you hold, or have you ever held, a license, certificate, registration or permit to practice nursing and/or any other regulated health occupation?
☐ Yes ☐ No

List all states, including Indiana, foreign territories, or countries, in which you hold or have held a license, certificate, registration or permit to practice nursing and/or any other regulated health occupation.

License Type	State / Country / Territory	Number	Date of Issue	Status

If your answer is "**Yes**" to any of the following, explain fully in a sworn affidavit, including all related details. Describe the event including the location, date and disposition. Falsification of any of the following is grounds for permanent revocation of the license or permit issued pursuant to this application.

1. Has disciplinary action ever been taken regarding any health license, certificate, registration or permit you hold or have held in **any** state or country? ☐ Yes ☐ No

2. Have you ever been denied a license, certificate, registration or permit to practice as a nurse or **any** regulated health occupation in **any** state or country? ☐ Yes ☐ No

3. Are there charges pending against you regarding a violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances, alcohol or other drugs? ☐ Yes ☐ No

4. Have you ever been convicted of, pled guilty or nolo contendre to:

   A. A violation of any Federal, State or local law relating to the use, manufacturing, distribution or dispensing of controlled substances, alcohol or other drugs? ☐ Yes ☐ No

   B. To any offense, misdemeanor or felony in any state? (*Except for minor violations of traffic laws resulting in fines*) ☐ Yes ☐ No

5. Have you ever been terminated, reprimanded, disciplined or demoted in the scope of your practice as a nurse or as another health care professional? ☐ Yes ☐ No

6. Have you ever had a malpractice judgement against you or settled any malpractice action? ☐ Yes ☐ No

7. Are you now being or have you ever been treated for a drug abuse or alcohol problem? ☐ Yes ☐ No

APPLICATION AFFIRMATION

I hereby swear or affirm under the penalties of perjury that the statements made in this application are true, complete and correct.

Signature of applicant	Date (*month, day, year*)

MANDATORY DISCLOSURE OF U.S. SOCIAL SECURITY NUMBER

Pursuant to Section 7 of the Privacy Act of 1974, you are hereby given notice that disclosure of your U.S. Social Security number on your application is mandatory for the purpose of complying with IC 25-1-5-8 and IC 4-1-8-1 which provide that the Indiana Department of Revenue may obtain Social Security numbers from the Health Professions Bureau for tax enforcement purposes. In addition, disclosing such number is mandatory in order for the licensing board or committee to comply with the requirements of the federal National Practitioner Data Bank and the Healthcare Integrity and Protection Data Bank 42 U.S.C. §1320(a)-7e(b), 5 USC §552a, 45 CFR Part 60.1, and 45 CFR Part 61.

Failure to disclose your U.S. Social Security number will result in the denial of your application. Application fees are not refundable.

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize, request and direct any person, firm, officer, corporation, association, organization or institution to release to the Health Professions Bureau of Indiana any files, documents, records or other information pertaining to the undersigned requested by the Bureau, or any of its authorized representatives in connection with processing my application for licensure as a nurse.

I hereby release the aforementioned persons, firms, officers, corporations, associations, organizations and institutions from any liability with regard to such inspection or furnishing of any information.

I further authorize the Health Professions Bureau of Indiana to disclose to the aforementioned persons, firms, officers, corporations, associations, organizations, and institutions any information which is material to my application, and I hereby specifically release the Bureau and the Indiana State Board of Nursing from any and all liability in connection with such disclosures.

A photostatic copy of this authorization has the same force and effect as the original.

AFFIRMATION

I hereby swear or affirm that I have read the above statements and agree to the same.

Signature of applicant	Date (*month, day, year*)

PLEASE TAPE YOUR PHOTOGRAPH BELOW (*DO NOT STAPLE*)

(*You must place your signature, the program director's signature and the school seal on the front of your photograph.*)

INDIANA STATE BOARD OF NURSING
Health Professions Bureau
402 West Washington Street, Room W066
Indianapolis, Indiana 46204
(317) 234-2043
http://www.state.in.us/hpb/boards/isbn/
email: hpb2@hpb.state.in.us

CERTIFICATE OF COMPLETION

☐ **RN** ☐ **LPN**

I hereby certify that_____ was admitted to the _____ Program of Nursing located in _____ on _____ and completed requirements for graduation on _____ will/did graduate on _____ . His/Her Social Security number is _____ .

There is evidence in our permanent records that this person has met the requirements as specified in Indiana law.

DATE:_____ SIGNED _____
Signature

SCHOOL SEAL

_____
Printed Name

_____
Dean / Director / Designee

APPLICANT: *The* ***CERTIFICATE OF COMPLETION*** *form must be completed and sent to the Health Professions Bureau by your program of nursing. You will not be declared eligible to take the examination until this form is received by the Health Professions Bureau.*

DIRECTOR OF PROGRAM: *The applicant cannot be declared eligible to take the examination until this form is received by the Health Professions Bureau.* ***CERTIFICATES OF COMPLETION SHOULD NOT BE SENT TO THE HEALTH PROFESSIONS BUREAU UNTIL THE APPLICANT HAS COMPLETED THE PROGRAM OF NURSING.***